

## CERTIFICATE OF DEATH

Reg. Dist. No.

14323

14348

1. PLACE OF DEATH a. COUNTY <b>Queen Anne</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Price</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>Price</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>John</b> First <b>Caulk</b> Middle <b>Lost</b>				4. DATE OF DEATH <b>December 9 1960</b> Month <b>Day</b> <b>Year</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Col.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>about 1900</b>	
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR <b>Months</b> <b>Days</b> <b>Hours</b> <b>Min.</b>		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>John Caulk</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>Informant</b> Address <b>Lillian Pierson--Price, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO (b) <b>Arteriosclerosis Generalized</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <b>331X</b> DUE TO (c) <b>Arteriosclerosis Generalized</b> INTERVAL BETWEEN ONSET AND DEATH <b>30 days</b> <b>years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Previous CVA</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Dec 7 1960</b> to <b>Dec 9 1960</b> , that I last saw the deceased alive on <b>Dec 7 1960</b> , and that death occurred at <b>10 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Centreville Md</b> DATE SIGNED <b>72-12-10</b> ACTUAL SIGNATURE <b>C. R. Layton</b> M.D. PHYSICIAN'S NAME (Type) <b>Centreville C. R. Layton</b>							
22a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 15</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Church Hill Col. Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Church Hill, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar L. Kane</b>				ADDRESS <b>Church Hill, Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 20 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>C. L. H. H. H.</b>			

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
TSM 9/58

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

14349

14324

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Queen Annes</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Annes</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Stevensville</b>		c. LENGTH OF STAY IN 1b <b>7 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Goldsborough Hall</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Stevensville</b>	
f. STREET ADDRESS <b>Goldsborough Hall</b>		g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>THE REV. HUGH VALENTINE CLARY</b>		4. DATE OF DEATH <b>December 7 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 2, 1892</b>
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Rector</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Episcopal Church</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Sidney Samuel Clary</b>		14. MOTHER'S MAIDEN NAME <b>Mary Edwina Fenner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>WW #1 220-34-9322</b>	
17. INFORMANT <b>Mrs Helen B. Clary, Stevensville, Md.</b>		Address <b>Box 27</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerotic coronary heart disease several years</b> DUE TO (c) <b>essential hypertension Arteriosclerosis 3 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Dec. 7, 1960</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>January 8, 1960</b> to <b>Dec 7</b> , 1960 that (I) (we) lost saw the deceased alive on <b>Dec 6</b> , 1960, and that death occurred on <b>Dec 7</b> AM, from the causes and on the date stated above.			
22a. SIGNATURE <b>Theodor Sattelmaier</b>		22b. DATE SIGNED <b>December 7, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Theodor SATTELMAIER, M.D. Stevensville, Maryland</b>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-9-60</b>	
23c. NAME OF CEMETERY <b>St. Mary's Episcopal</b>		23d. LOCATION (City, town, or county) (State) <b>Pocomoke City, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Henry A. Watson</b>		25a. REC'D BY REGISTRAR <b>DEC 12 '60</b>	
ADDRESS <b>Pocomoke City, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Knud</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

14325

14350

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Loyle Mills</u>	c. LENGTH OF STAY IN 1b <u>Life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Loyle Mills</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARRY EISK DENNY</u>		4. DATE OF DEATH Month Day Year <u>Dec 17 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 3-1888</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	11. BIRTHPLACE (State or foreign country) <u>Wyo. Mills Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>10th Henry Denny</u>	
14. MOTHER'S MAIDEN NAME <u>Sallie Skinner</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>215-36-7277A</u>		17. INFORMANT Address <u>Myra S. Denny, Wyo. Mills Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> 4 20.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>5 wks</u> <u>3 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug</u> , 19 <u>60</u> , to <u>Dec</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Dec 16</u> , 19 <u>60</u> , and that death occurred at <u>6:30</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Queenstown, Md</u> DATE SIGNED <u>12/20/60</u>			
ACTUAL SIGNATURE <u>Irvin G. Hoyt</u> M.D.		PHYSICIAN'S NAME (Type) <u>Irvin G. Hoyt MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>Dec 19-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Memorial</u>	22d. LOCATION (City, town, or county) (State) <u>in Eastern Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter B. Carter</u> ADDRESS <u>Walter B. Carter</u>		24a. RECD BY REGISTRAR <u>Walter B. Carter</u> DATE <u>12/20/60</u>	24b. REGISTRAR'S SIGNATURE <u>Walter B. Carter</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14351

CERTIFICATE OF DEATH

Reg. Dist. No.

14326

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevensville Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevensville Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Jessie</u> First <u>Green</u> Middle Last		4. DATE OF DEATH <u>December</u> Month <u>9th</u> Day <u>1960</u> Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-20-91</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wagoner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Longing oysters</u>	
11. BIRTHPLACE (State or foreign country) <u>STEVENSVILLE, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Alexander Green</u>		14. MOTHER'S MAIDEN NAME <u>Bertude Hazelton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-104193</u>	
17. INFORMANT <u>Daisy Green</u> Address <u>Stevensville Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute intestinal obstruction ileus</u> <u>156</u> DUE TO <u>Carcinoma atosis liver, stomach + intestines (TB.)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>1954</u> (c) <u>Tuberculosis of lungs, treated at Mount Wilson</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE IMMEDIATE CAUSE GIVEN IN PART I (a) <u>perforated gastric ulcers</u> 1950. operation		INTERVAL BETWEEN ONSET AND DEATH <u>Dec. 8, 1960</u> <u>about 6</u> Months <u>1954</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>002X</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 8th</u> , 19 <u>60</u> , to <u>Dec 9</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Dec. 9</u> , 19 <u>60</u> , and that death occurred at <u>10 A. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Theodor Sattelmaier</u> M.D.		ADDRESS (Street, city or town, state) <u>STEVENSVILLE, MARYLAND</u> DATE SIGNED <u>Dec 9, 60</u>	
PHYSICIAN'S NAME (Type) <u>Theodor SATTELMAIER</u>		<u>Stevensville, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/14/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Stevensville, Md.</u>	22d. LOCATION (City, town, or county) (State) <u>Stevensville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James K. Schell</u> ADDRESS <u>Easton Md.</u>		24a. REC'D BY REGISTRAR DATE <u>Dec 20 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kraus</u>	

CERTIFICATE OF DEATH

1. Name of deceased: JOHN J. SMITH

2. Sex: Male

3. Age: 45

4. Date of death: March 15, 1945

5. Time of death: 10:30 AM

6. Place of death: Home

7. Cause of death: Myocardial Infarction

8. Duration of illness: 2 days

9. Name of attending physician: Dr. J. H. Jones

10. Name of medical examiner: Dr. A. B. Smith

11. Name of funeral director: Mr. C. D. Brown

12. Name of informant: John J. Smith

13. Address of informant: 123 Main St., New York City

14. Signature of informant: [Signature]

15. Signature of medical examiner: [Signature]

16. Signature of funeral director: [Signature]

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any part is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH e. COUNTY <b>Queen Anne</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Chestertown</b> c. LENGTH OF STAY IN 1b <b>lifetime</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Found dead in snow (Union Church)</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Chestertown, Md.</b> d. STREET ADDRESS <b>Rural</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Walter R. Green</b>		4. DATE OF DEATH <b>Dec. 12 1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 14, 1934</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>farm</b>	9. AGE (in years last birthday) <b>26</b> IF UNDER 1 YEAR: Months <b>12</b> Days <b>2</b> IF UNDER 24 HRS.: Hours <b>12</b> Min. <b>00</b>
11. BIRTHPLACE (State or foreign country) <b>Queen Anne Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Green</b>		14. MOTHER'S MAIDEN NAME <b>Mary Anderson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>Doris Green RFD # 1</b>	
17. INFORMANT <b>Doris Green</b>		Address <b>Chestertown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Exposure to Cold</b> DUE TO (b) <b>932.1</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last, <b>2 hours</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Went out to inspect Roads</b>	
20c. TIME OF INJURY Month, Day, Year <b>6 12-12-60</b> Hour a.m. <b>12</b> p.m. <b>12</b>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>farm</b>	20f. (City or town) <b>Rural Chestertown Md</b> (County) <b>QA</b> (State) <b>MD</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>C. T. Layton</b> EXAMINER'S NAME (Type) <b>C. T. Layton</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Dec 22, 1960</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/24/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rich Neck Hall Cem.</b>	22d. LOCATION (City, town, or country) (State) <b>near Chestertown, Md.</b>
23. FUNERAL DIRECTOR <b>Benneth Welby</b> ADDRESS <b>Chestertown, Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 27 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>

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Reg. Dist. No. 14328

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grasonville</u>		c. LENGTH OF STAY IN 1b <u>6 years</u> X <u>Grasonville</u>	
c. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Presley</u> First <u>Guessford</u> Middle <u>Guessford</u> Last		4. DATE OF DEATH <u>December</u> Month <u>18</u> Day <u>1960</u> Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 12 - 1873</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Trust</u>	11. BIRTHPLACE (State or foreign country) <u>Centerville, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>James Guessford</u>		14. MOTHER'S MAIDEN NAME <u>Barah Elizabeth Leverage</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>217-30-8479</u>	
17. INFORMANT <u>Lillie May Coughlin Grasonville</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Arteriosclerosis general + cerebral</u> DUE TO (c) <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>Dec. 18, 1960</u> <u>about 10 years</u> <u>about 5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 10</u> , 19 <u>54</u> to <u>Dec. 18</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Dec. 17</u> , 19 <u>60</u> , and that death occurred at <u>9 A.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Theodor Sattelmair</u> M.D. <u>STEVENSVILLE Md.</u>		DATE SIGNED <u>Dec 19, 1960</u>	
PHYSICIAN'S NAME (Type) <u>Theodor SATTELMAIER</u>		<u>Stevensville Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec 20-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Christiansburg</u>	22d. LOCATION (City, town, or county) (State) <u>Centerville Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Stevensville Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>DEC 27 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Knaus</u>	



14354

## CERTIFICATE OF DEATH

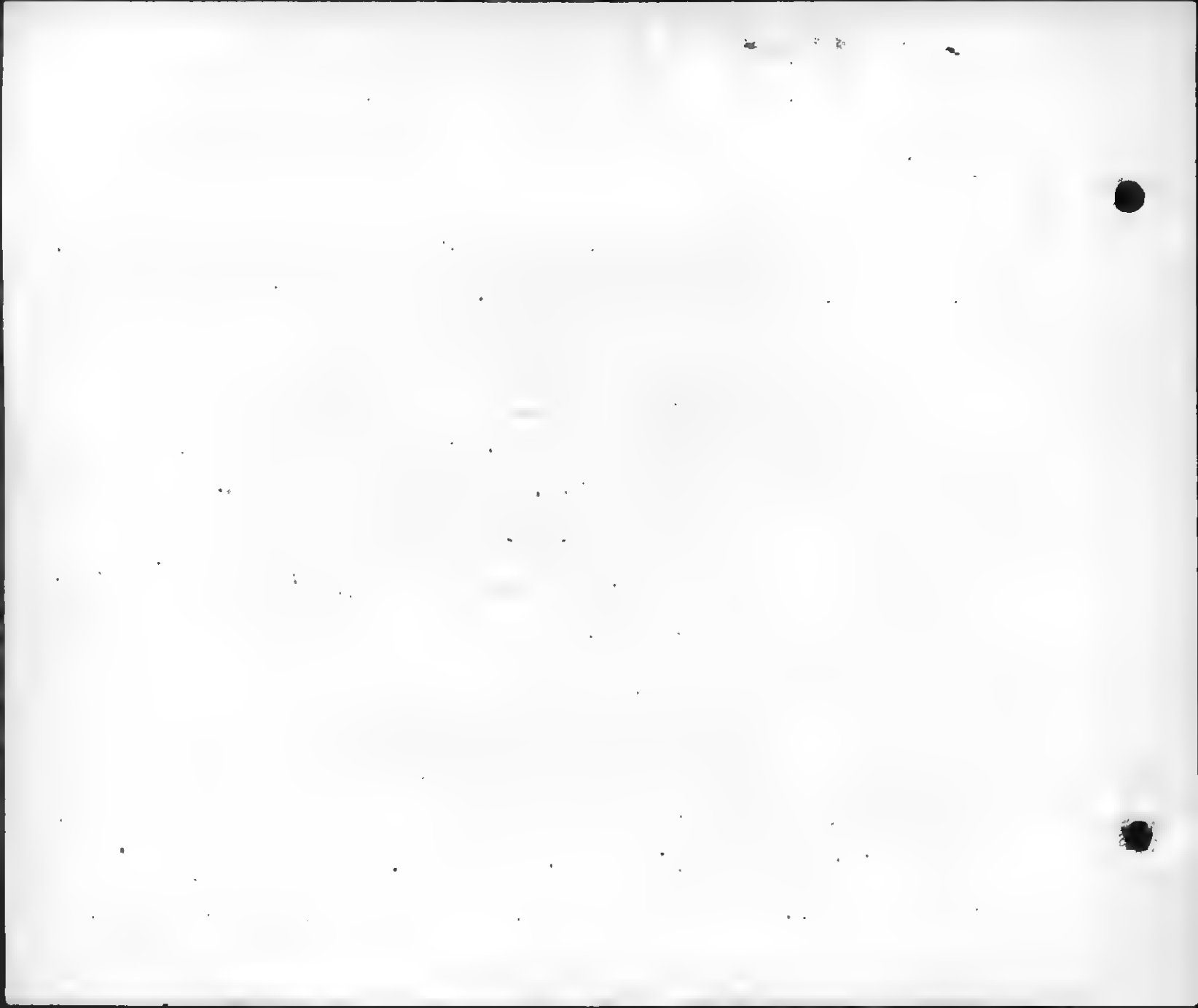
14329

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Queen Anne</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chester</b>		c. LENGTH OF STAY IN 1b <b>Chester</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Henry</b> <b>Hill</b> <b>Hoxter</b>		4. DATE OF DEATH Month <b>December</b> Day <b>13</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 14-1895</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>5</b>	11. IF UNDER 24 HRS Hours <b>13</b> Min. <b>19</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Curtis Hoxter</b>		14. MOTHER'S MAIDEN NAME <b>Mary Thomas</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>INFORMANT</b> Address <b>Mrs. Hill Hoxter Chester, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary occlusion (died in ambulance to hospital) Dec. 13, 1960</b> 4400-1 DUE TO (b) <b>hypertensive Cardio-vascular disease</b> 6 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO (c) <b>Arteriosclerosis, essential hypertension</b> 8 years PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>broken vertebrae (fall from ladder 1953)</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>th</b>	
21. I certify that I attended the deceased from <b>March 10, 1950</b> to <b>Dec 13, 1960</b> , that I last saw the deceased alive on <b>Dec. 13, 1960</b> , and that death occurred at <b>3 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Stevensville Md</b> <b>Dec. 14, 1960</b>			
ACTUAL SIGNATURE <b>Theodor Sattelmair</b>		M.D. <b>Stevensville Md</b>	
PHYSICIAN'S NAME (Type) <b>Theodor SATTELMAYER M.D.</b>		<b>STEVENSVILLE, Md</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec. 16</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Stevensville</b>	22d. LOCATION (City, town, or county) (State) <b>Stevensville Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar L. Lane</b>		24a. REC'D BY REGISTRAR <b>DEC 20 '60</b>	
ADDRESS <b>Church Hill, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>But S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the bur or-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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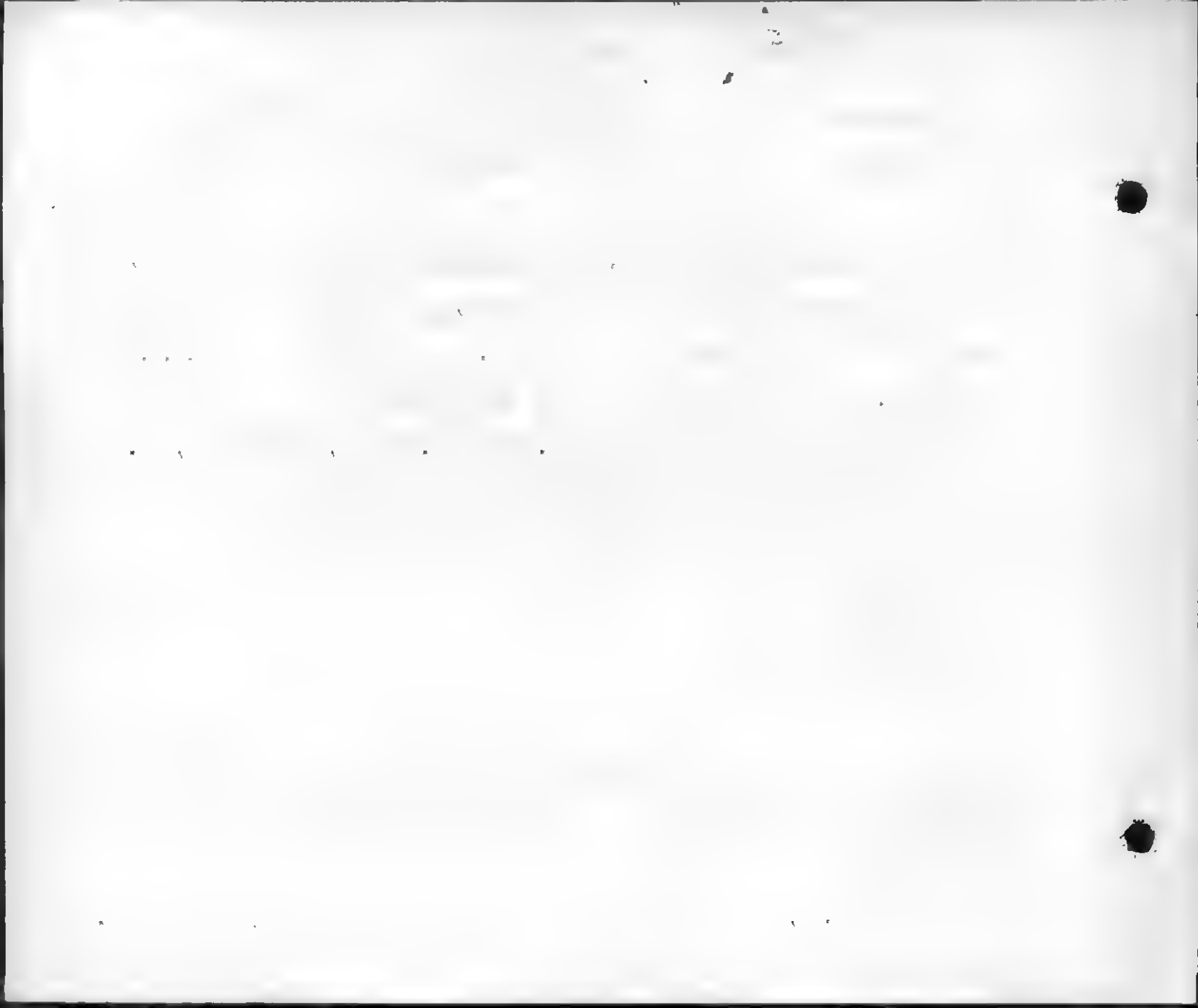
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 14330

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Millington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Millington</u>			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS <u>7</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>E.</u> Last <u>Jackson</u>				4. DATE OF DEATH Month <u>December</u> Day <u>15</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 1, 1916</u>	
9. AGE (In years last birthday) <u>44</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles H. Pyle</u>				14. MOTHER'S MAIDEN NAME <u>Mary Hevelow</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) [If yes, give war or dates of service] <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. ADDRESS <u>Rural</u>				18. INFORMANT <u>Mr. Elwood H. Jackson, Millington, Md.</u>			
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Decompensation of the heart</u> DUE TO <u>241X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Degeneration of the heart muscle</u> DUE TO (c) <u>Bronchial Asthma</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4-5 months</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>5 years</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month <u>14</u> Day <u>19</u> Year <u>1960</u> Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 24</u> , 19 <u>60</u> , to <u>Dec. 15</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Dec. 14</u> , 19 <u>60</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above							
ACTUAL SIGNATURE <u>Geza Koralewski</u>				ADDRESS (Street, city or town, state) <u>MILLINGTON, MD</u> DATE SIGNED <u>12.16.60</u>			
PHYSICIAN'S NAME (Type) <u>GEZA KORALEWSKI</u>							
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 18, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sudlersville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Sudlersville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward L. Lewis</u>				24a. REC'D BY REGISTRAR <u>DEC 19 1960</u>		24b. REGISTRAR'S SIGNATURE <u>William L. Thomas</u>	



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**14356**  
**CERTIFICATE OF DEATH**

Reg. Dist. No. **14331**

1. PLACE OF DEATH o. COUNTY <u>Queen Anne's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Q. A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queenstown-Rural</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Queenstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Clifton</u> Last <u>Kinnaman</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>8</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 30, 1934</u>		9. AGE (In years last birthday) <u>26</u> yrs	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John E. Kinnaman Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Mary Palmer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Mary Palmer, Queenstown, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>260X</u> DUE TO <u>Quemisia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO <u>Dilated Myelitis</u> DUE TO <u>—</u> DUE TO <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>20 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>60</u> , to <u>Dec.</u> , 19 <u>60</u> that I last saw the deceased alive on <u>Dec 8</u> , 19 <u>60</u> , and that death occurred at <u>7:45</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Queenstown, Md</u> DATE SIGNED <u>12/8/60</u>							
ACTUAL SIGNATURE <u>Irvin G. Hoyt MD</u> M.D.				PHYSICIAN'S NAME (Type) <u>Irvin G. Hoyt MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 11 - 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Stinsonville</u>		22d. LOCATION (City, town, or county) (State) <u>Stinsonville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Thomas Baile</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 20 1960</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

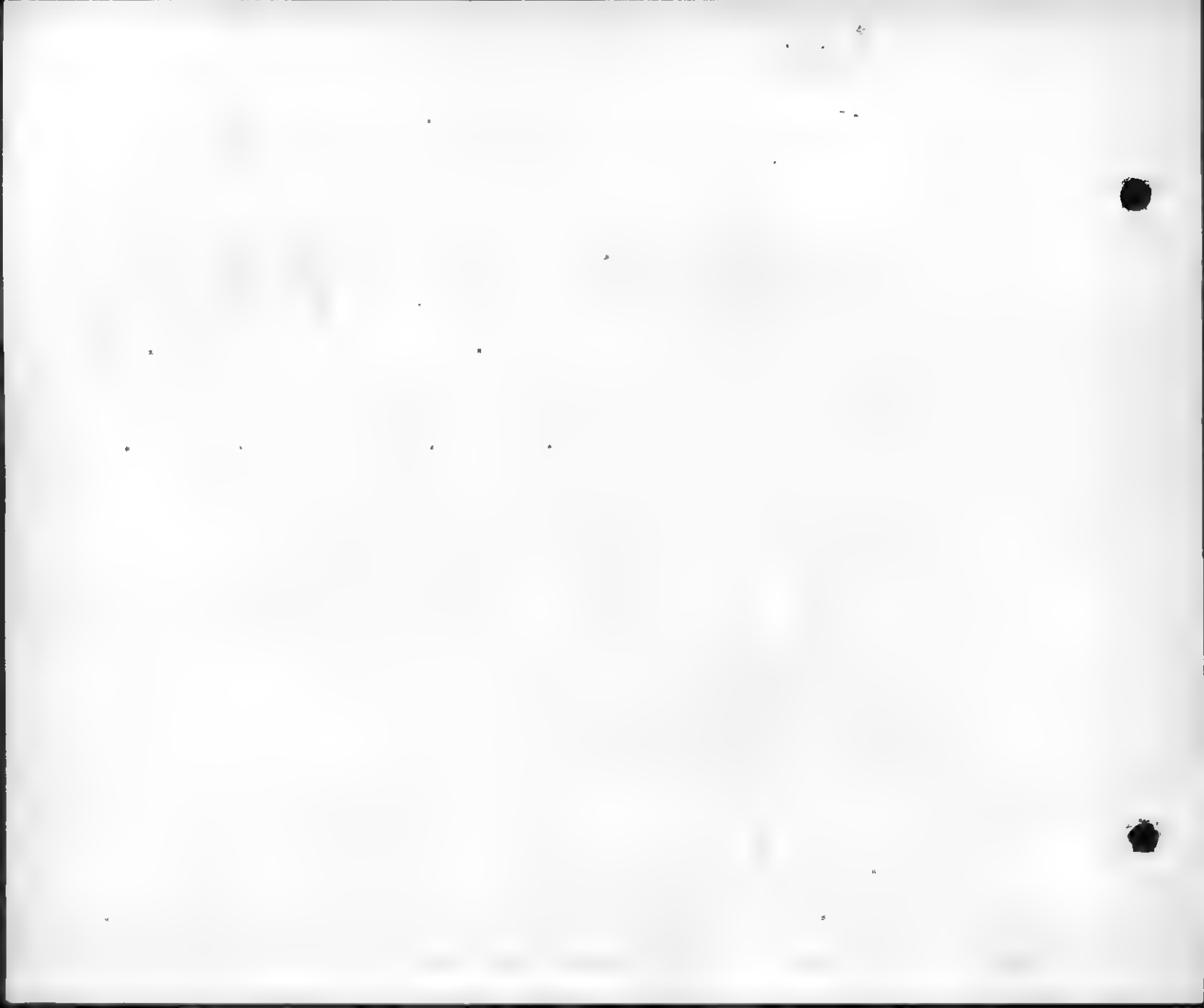
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14357

CERTIFICATE OF DEATH

Reg. Dist. No. 14352

1. PLACE OF DEATH a. COUNTY <b>Queen Anne</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Queen Anne</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crumpton</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crumpton</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <b>Nellie</b> Middle <b>V.</b> Last <b>Klugh</b>				4. DATE OF DEATH Month <b>December</b> Day <b>14</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 29, 1880</b>		9. AGE (In years lost birthday) yrs. <b>80</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Philman Lloyd</b>				14. MOTHER'S MAIDEN NAME <b>? Robinson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>		INFORMANT Address <b>Mr. George L. Klugh Crumpton, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>592x</b> <b>Cough &amp; Decompensation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Chronic myocardial</b> (c) <b>Chronic Bronchitis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pneumonia</b>							
INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>1960</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 15</b> , 1935, to <b>Dec 14</b> , 1960, that I last saw the deceased alive on <b>Dec 10</b> , 1960, and that death occurred at <b>5 P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>C. H. Metcalfe</b> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <b>Dec 12/16/60</b>			
PHYSICIAN'S NAME (Type) <b>C.H. Metcalfe</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 17, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Crumpton Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Crumpton, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward S. Lowe</b>				ADDRESS <b>Mt. Airy, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 19 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			



may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14358

CERTIFICATE OF DEATH

Reg. Dist. No. 14353

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Luke's Breeding Home</u>		e. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY EFFIE (ROE) MACFARLAN</u>		4. DATE OF DEATH Month Day Year <u>Dec. 7 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 22 - 1876</u>
9. AGE (In years last birthday) <u>83</u> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>in Carmichael 206 Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Emory Theodore Roe</u>		14. MOTHER'S MAIDEN NAME <u>Mary Temperance Brington</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs Mary Ann Roe Mason, Wye Mills Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension - Arteriosclerosis - Heart Disease</u> DUE TO (c) <u>Dehydration</u>			INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 1954</u> to <u>Dec. 1960</u> , that I last saw the deceased alive on <u>Dec. 7, 1960</u> , and that death occurred at <u>3 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Irvin G. Hoyt</u> M.D.		ADDRESS (Street, city or town, state) <u>Centerville Maryland</u>	
PHYSICIAN'S NAME (Type) <u>Irvin G. Hoyt MD</u>		DATE SIGNED <u>12/7/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 10-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Centerville</u>		22d. LOCATION (City, town, or county) (State) <u>Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Edward Barton of Barton Bros Centerville Md</u>		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>	
DATE <u>DEC 20 '60</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 14359 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **14354**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Queen Anne</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Q. Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queenstown</u>		c. LENGTH OF STAY in 1b <u>59 yrs.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queenstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>William</u> Middle <u>George</u> Last <u>Schelberg</u>				<b>4. DATE OF DEATH</b> Month <u>Dec.</u> Day <u>10</u> Year <u>1930</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 3, 1901</u>	
9. AGE (In years last birthday) <u>29</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Seafood</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>August Schelberg</u>				14. MOTHER'S MAIDEN NAME <u>Henora Elser</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Mrs. Alfred Schweizer</u> Address <u>803 Elizabeth St.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured Abdominal Aneurysm</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Irvin G. Hoyt, M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Irvin G. Hoyt, M.D.</u>				DATE SIGNED <u>  </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>DEC 20 1930</u>	
24b. REGISTRAR'S SIGNATURE				<u>  </u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

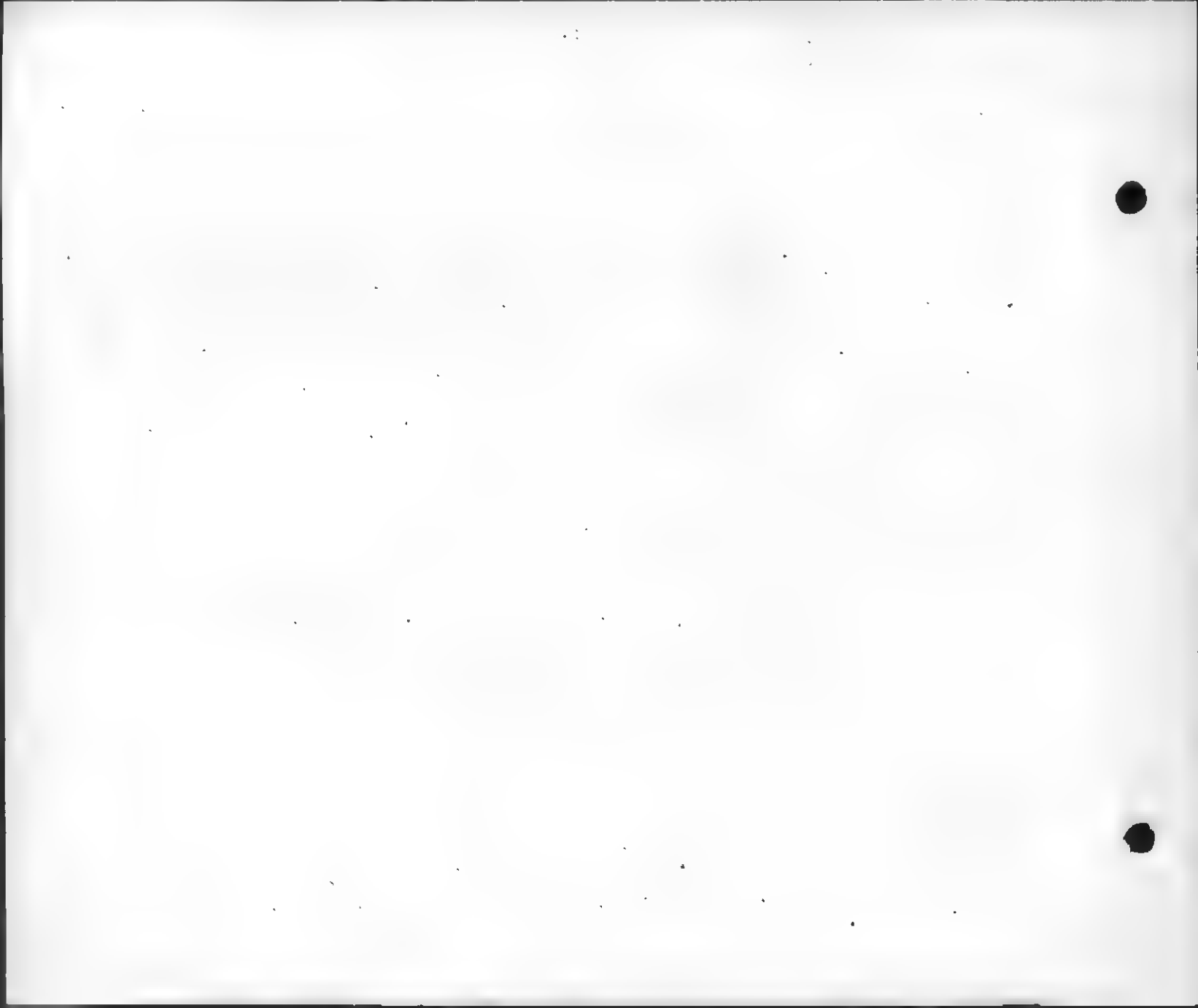


14360

CERTIFICATE OF DEATH

Reg. Dist. No. 14350

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queen Anne (Rural)</u>		2. USUAL RESIDENCE (Where deceased lived If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queen Anne (Rural)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Palashia</u> <u>Trutowska</u> First Middle Last		4. DATE OF DEATH <u>Dec</u> Month <u>26</u> Day <u>1960</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 12, 1886</u>
9. AGE (In years, months, and days) <u>74</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Ukraine (Europe)</u>		12. CITIZEN OF WHAT COUNTRY? <u>Ukraine (Europe)</u>	
13. FATHER'S NAME <u>Porfiy Kremena</u>		14. MOTHER'S MAIDEN NAME <u>Natalia Tkach</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Eugene Cherevko</u> Address <u>Queen Anne Md</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause (c), stating the <u>underlying</u> cause lost. (b) <u>Coronary artery sclerosis</u> (c) <u>Chronic leg ulcers due to thrombophlebitis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Over 10 years</u> <u>same</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 4</u> 19 <u>50</u> to <u>Dec 26</u> 19 <u>60</u> , that I last saw the deceased alive on <u>Dec 23</u> 19 <u>60</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>Kurt Lederer</u> M.D. <u>Dec 29, 1960</u>		PHYSICIAN'S NAME (Type) <u>KURT LEDERER</u> <u>QUEEN ANNE MD</u>	
22a. BURIAL, CREMATION, REINTERMENT <u>Burial</u>		22b. DATE THEREOF <u>12/28/60</u>	
22c. NAME OF CEMETERY OR CREMATOR <u>Spring Hill Cemo</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice Newman</u> ADDRESS <u>Easton Md</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 3 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>William S. H.</u>			



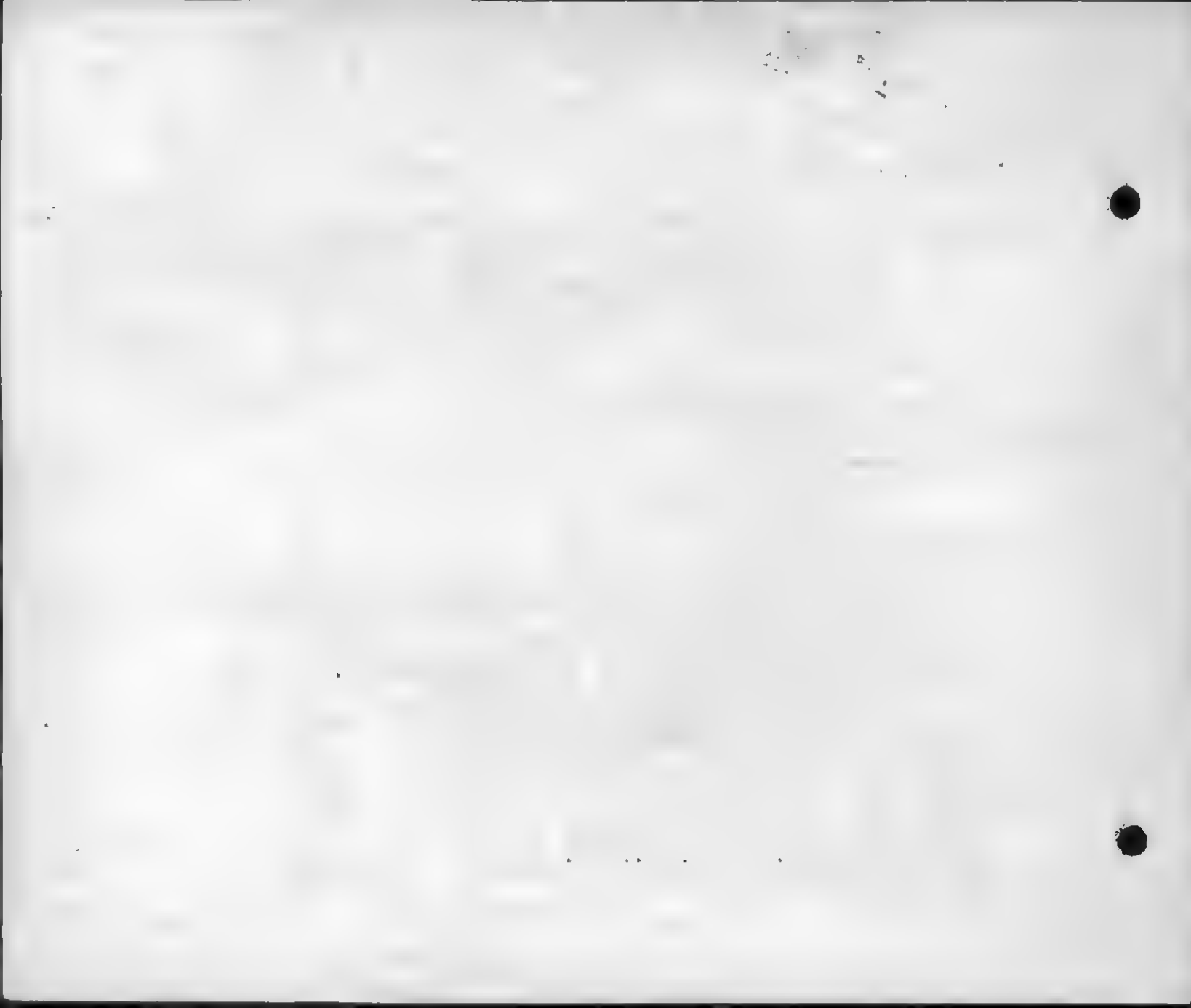
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any cause is necessary, any cause should be stated in the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>QUEENS ANNE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>NEAR STEVENSVILLE</b> c. LENGTH OF STAY IN town d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>QUEENS ANNE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Stevensville</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES HERMAN VOELKER</b>		4. DATE OF DEATH found Month Day Year <b>December 2 1960</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 20, 1942</b>	
9. AGE (In years last birthday) <b>18</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School boy</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles H. Voelker</b>		14. MOTHER'S MAIDEN NAME <b>Nancy M. Clark</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>212-40-9222</b>	
17. INFORMANT <b>Nancy M. Hogter (mother)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> 929.8 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Undetermined how drowning occurred.</b>	
20c. TIME OF INJURY Month, Day, Year <b>found 12:30 P.m. 12/2/60</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>water</b>		20f. (City or town) (County) (State) <b>Centerville Queens Anne Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <b>William V. Lovitt, Jr.</b>		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec 4-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Stevensville</b>		22d. LOCATION (City, town, or country) (State) <b>Stevensville Md</b>	
23. FUNERAL DIRECTOR <b>Edgar L. Lane Church Hill Md</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>DEC 12 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles L. Hume</b>	



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## 14362

## CERTIFICATE OF DEATH

14337

1. PLACE OF DEATH a. COUNTY <b>Queen Anne</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crumpton (Pondtown)</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wright Nursing Home</b>				d. STREET ADDRESS <b>Calvert St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>John Wells</b>				4. DATE OF DEATH <b>Dec. 26, 1960</b>		Month <b>Dec.</b> Day <b>26</b> Year <b>19</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>? ? 1876</b>			
9. AGE (In years last birthday) <b>84</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>John Wells</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-03-4764</b>		17. INFORMANT <b>Fannie Wilson</b> Address <b>Calvert St. Chestertown, Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>422-1</b> DUE TO <b>Paralysis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral infarction</b> (c) <b>Paul Vorhies Schuss</b>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Stroke</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>12</b>		20d. INJURY OCCURRED While of work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 1, 1960</b> to <b>Dec 26, 1960</b> , that (I) (we) last saw the deceased alive on <b>Dec 20, 1960</b> , and that death occurred at <b>9 PM</b> , from the causes and on the date stated above									
22a. SIGNATURE <b>C. H. Metcalfe</b>				M.D. ATTENDING PHYS. # MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12/27/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>C. H. Metcalfe</b>				22d. ADDRESS <b>Sudlersville, Md.</b>					
23a. BURIAL CREMATION, (Specify)		23b. DATE THEREOF <b>12/28/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Janes Cemetery (col)</b>		23d. LOCATION (City, town, or county) (State) <b>near Chestertown, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Kraus</b>				ADDRESS <b>Chestertown, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 3 '61</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>									



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14363

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 14358

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Centerville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural-Centerville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R.F.D. #1</u>		d. STREET ADDRESS <u>1 R.F.D. #1</u>	
3. NAME OF DECEASED (Type or print) <u>Charles Henry Wheeler</u>		4. DATE OF DEATH <u>Dec 12 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 12, 1949</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Student</u>	
11. BIRTHPLACE (State or foreign country) <u>Price, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Fletcher Wheeler</u>		14. MOTHER'S MAIDEN NAME <u>Edna Copper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Fletcher Wheeler</u>		Address <u>Centerville, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exposure to Cold Frozen</u> 9320 DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO cause last. (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Lost from Parent in Storm</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input checked="" type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Rural QA Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>C. R. Bayton</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>C. R. Bayton</u>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/17/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Roseville Ceme</u>		22d. LOCATION (City, town, or county) (State) <u>Church Hill, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard M. St. Lawrence</u>		ADDRESS <u>Cambridge, Md</u>	
24a. REC'D BY REGISTRAR <u>DEC 21 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 14339

14364

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Centerville</u>		c. LENGTH OF STAY IN TB <u>Life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R.F.D. #1</u>		d. STREET ADDRESS <u>1 R.F.D. #1</u>	
3. NAME OF DECEASED (Type or print) <u>Donald Sylvester Wheeler</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>12</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 16 1955</u>
9. AGE (in years) <u>5</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Student</u>	
11. BIRTHPLACE (State or foreign country) <u>Priest, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Fletcher Wheeler</u>		14. MOTHER'S MAIDEN NAME <u>Edna Copper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Fletcher Wheeler, Centerville, Md</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>932.0</u> DUE TO <u>Exposure to Cold-Frozen</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> DUE TO <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>2h</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>  </u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Lost from parent in storm</u>	
20c. TIME OF INJURY Month, Day, Year <u>Dec 12 1960</u> Hour <u>6:00</u> a. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Rural</u> (County) <u>QA</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>C. R. Lantton</u>		DATE SIGNED <u>12-12-60</u>	
EXAMINER'S NAME (Type) <u>C. R. Lantton</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/17/1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Roseville, Ceme</u>		22d. LOCATION (City, town, or county) <u>Church Hill, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert M. St. Lawrence, Cambridge, Md</u>		24a. REC'D BY REGISTRAR <u>  </u> 24b. REGISTRAR'S SIGNATURE <u>  </u>	
DATE <u>DEC 21 '60</u>			

14-0000

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BUREAU OF VITALS

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

SEX

AGE

HEIGHT

WEIGHT

TEMPERATURE

PULSE

BLOOD PRESSURE

RESPIRATIONS

DIAGNOSIS

TESTS

TREATMENT

PROGNOSIS

REMARKS

SIGNATURE

DATE